VAN DE WARKER (Ely.)

A Successful Case of Laparo-Hysterectomy for Uterine Fibroids.

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A SUCCESSFUL CASE OF LAPARO-HYSTERECTOMY FOR UTERINE FIBROIDS.*

By ELY VAN DE WARKER, M. D.,
SYRACUSE, N. Y.

On November 13, 1883, I was called, in connection with Dr. John Van Duyn, to examine Mrs. B., aged thirty-eight, a small brunette, married fourteen years, with one child three years old. On inspection, the abdomen was enlarged in excess somewhat of the ninth month of pregnancy, but not uniform in contour, as the umbilicus was distorted nearly three inches to the right. Fluctuation was marked, but diffuse, to the left and lower portion of the abdomen, well defined by what was evidently a cyst-wall in the upper portion, and was absent on the right side. There was general dullness on percussion except over the colon on the left side. A hypodermic needle inserted in the middle line gave us a small sample of coffee-colored fluid, which coagulated by heat and redissolved on the addition of acetic acid into a fine, flocculent precipitate. Examining through the vagina, we had difficulty in reaching the cervix uteri owing to its high situation; it was crowded to the left and forward. A sound was with some difficulty introduced into the uterine cavity, which gave a measurement of seven inches. Its direction was

* Read by Dr. Paul F. Mundé before the New York Obstetrical Society, March 4, 1884.

obliquely to the right. Manipulation of the tumor through the abdominal walls imparted free movement to the sound. With the patient in the knee-face position, the tumor did not recede from the pelvic brim, or the uterine position perceptibly change.

The history which was given by her physician, Dr. Dann, who was present, was somewhat peculiar. An enlargement of the lower abdomen upon the left side was first noticed four years ago. Shortly after this discovery a second tumor began to develop in a more central position. Both tumors gradually increased in size. She passed into the hands of several physicians, who gave various opinions. She then passed into the hands of Dr. Dann, who expressed the opinion that the central tumor was a pregnant uterus. In due time she gave birth to a male child.

In view of these facts, Dr. Van Duyn and I came to the following conclusion: That the tumor was a cyst of the left ovary, with probably a dense and thickened cyst-wall on the right side; that the uterus during the pregnant condition formed firm adhesions to the cyst-wall to the right, which adhesions prevented the return of the organ to the pelvic cavity, and gradually elongated the uterus as the cyst increased in size; and, lastly, that there were firm pelvic adhesions. This diagnosis proved correct only in part.

On the 3d of December, assisted by Dr. Van Duyn, Dr. Creveling, of Auburn, and Dr. Dann, of Syracuse, I operated, Through an incision in the abdominal wall the hand was introduced to explore the relations of the cyst. Adhesions to the abdominal walls were quite general and firm. The exploration showed that the pelvic relations of the tumor were of an unusual character. Reflected downward from the right, left, and anterior lower surfaces of the cyst, was a firm, smooth membrane which connected it with the pelvic brim from the extreme right to left. At the mesial line, extending upward, was a process of the membrane that connected the cyst to the abdominal wall, nearly as high as the umbilicus. This process enabled us to determine the character of the pelvic attachments,

The process was a duplication of the peritonæum, which at this point was reflected from the abdominal wall over the cyst, while the same membrane was prolonged upward from the pelvic brim over the tumor. Thus the growth was subperitoneal. The cyst was emptied, some omental and mesenteric adhesions were ligated and divided, and it was lifted from the abdominal cavity. The cause of dullness upon the right side was then revealed; it was a large fibroid tumor connected by a broad, flat pedicle with the uterus. The course of vessels through the peritoneal expansions could now be plainly seen; those which were large enough were secured by passing a ligature through the membrane and tying, and then dividing by the knife, keeping close to the cyst-wall. In this manner the pelvic attachments were worked through. What appeared to be the original pedicle of the tumor upon the left side and imbedded in the peritoneal duplicature was secured with a double ligature which was cut short and no further attention paid to it. This stage of the operation having been completed, nothing connected the mass with the pelvic cavity except the uterus, which was so thoroughly incorporated with the cyst-wall as to be scarcely distinguishable. The uterine neck was transfixed by a strong needle armed with a double braided silk ligature, which was tied in opposite directions and cut short, and the uterus divided close to the tumor. The uterine stump was lightly cauterized. The toilet of the peritonæum was carefully made. A one-half-inch drainage-tube was passed down into Douglas's sac. The stump was transfixed by two steel bonnet-pins and brought out of the lower angle of the abdominal wound. The peritonæum was made to embrace the stump by a suture passed through it, modified after the method of Hegar, above which the drainage-tube protruded. The abdominal wound was brought together with silk sutures and dressed with dry absorbent cotton.

There was very little shock, and the patient reacted well. Time of the operation, one hour and ten minutes.

The sponges were cleaned in carbolized water. A carbolized-spray apparatus was working in the room, but was not directed upon the patient.

The uterine stump was dressed with a solution of corrosive sublimate, on absorbent cotton wrung nearly dry, four grains to the ounce, and was kept perfectly dry and free from odor. On the tenth day a thin slough, due to the cautery, separated.

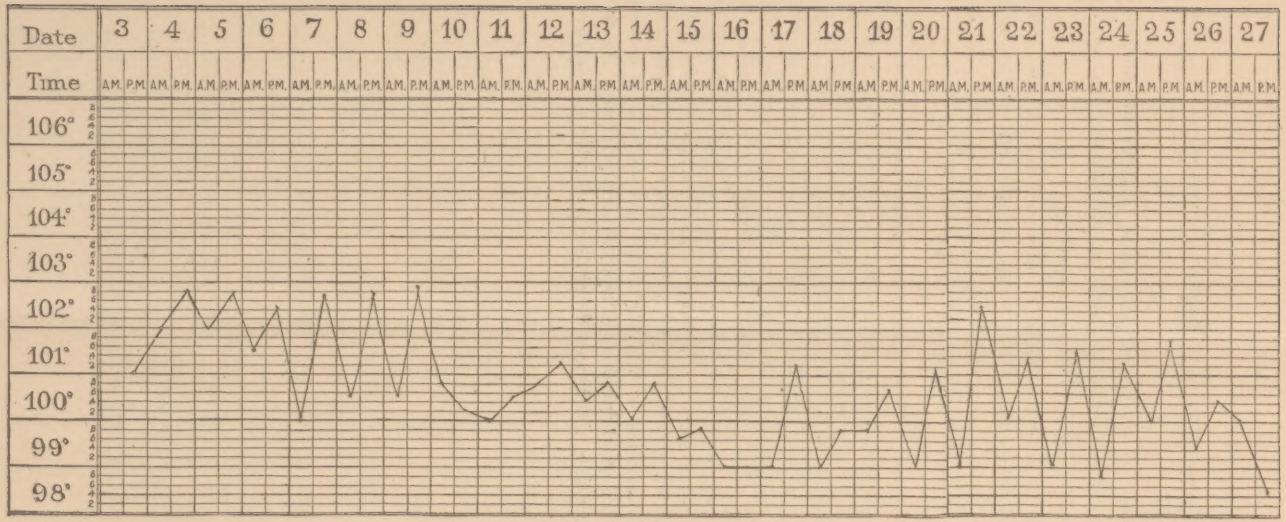
On the seventeenth day the drainage-tube was removed. It was washed out twice a day by means of a rubber tube passed to the bottom connected with a glass syringe, at first with a solution of carbolic acid, 1 to 40, and latterly with a solution of corrosive sublimate, 1 to 1,000. The power of the sublimate solution to deodorize the stump and tube was remarkable. No discharge was ever obtained through the tube, which appeared to me to do very little, if any, good.

On the nineteenth day the bonnet-pins were removed. The stump was firmly united to the abdominal wall. This took place very early in the treatment, so that the stump was shut off from the abdominal cavity. Anodynes were sparingly used, and none after the third day. Some abdominal pain, slight distension, and rectal tenesmus on the sixth day were promptly cured by a free dose of castor-oil.

On the twenty-first day she sat up for a short time. The temperature record is shown in the annexed chart.

The ligature upon the uterine stump has not been removed, and has given no trouble.

The case is placed upon record for the following reasons: First. The vitality of the stump was preserved beyond the ligature by compression with the ligature just sufficient to arrest active hæmorrhage, while oozing was checked by slight contact with the actual cautery. In this way we avoided a large sloughing mass in the open abdominal wound, as is the case after the use of the *serre-nœud*, or the elastic ligature of Hegar. Second. By securing early union of the surface of the stump to the abdominal wall by careful coaptation of the peritonæum around it (Hegar), and thus closing the cavity of the abdomen. This was secured by my method, but was violated by the drainage-tube, which I regard as a mistake. Third. The free use of corrosive-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sublimate solution as an antiseptic, which was employed in preparing the ligatures, dressing the stump, and in irrigating the drainage-tube and vagina.

The present condition of Mrs. B. deserves one comment. Previous to the operation she was the subject of mild mania. Before her convalescence was established she became entirely sane, and remains in that condition.

NOTE, *July 29th.*—The ligature upon the uterine stump came away early in April. The lower extremity of the abdominal wound is now defined by a central depression 1 cm. in depth, at the bottom of which the uterine stump appears, slightly elevated, conical, smooth, and red, with a central opening that will receive a small probe which corresponds to the canal of the cervix. The stump is firmly adherent to the abdominal wall, and will evidently never recede into the abdominal cavity. A light dressing of absorbent cotton, renewed twice a day, is required to keep the cavity dry. When the weather becomes cooler Mrs. B. has consented to have the uterine stump covered. The operation will consist of raising flaps of the integument upon each side of the abdominal depression and bringing them together over the stump. In this manner a condition that annoys the patient very much, it is hoped, may be removed. V.

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